PROVINCIAL PROFILE OF WOMEN'S HEALTH:

UPDATED DATA ON SELECTED INDICATORS

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Ministry of Health and
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WOMEN'S HEALTH BUREAU

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PREFACE

The Provincial Profile of Women's Health: Updated Data on Selected Indicators contains the most recent data on selected women's health indicators from the May 1999 edition (*Provincial Profile of Women's Health: A Statistical Overview of Health Indicators for Women in British Columbia*). These documents were created after listening to health authorities talk about what they needed to address women's health in their health authority areas.

The *Profile of Women's Health* is one of many initiatives of the Women's Health Bureau to support health authorities in planning for women's health and monitoring services in their local health authority areas. An example of such an initiative is the document, *Health Goals for British Columbia Women* (2000). *Health Goals* is an innovative work that applies the six generic provincial health goals – developed after extensive consultation and approved by the provincial government in July 1997 – to women's health. *Health Goals* provides objectives, indicators, and strategies that can be used to assist health authorities with setting targets and developing initiatives to address and enhance women's health. The *Profile of Women's Health* and *Health Goals* are resources that may be used in conjunction with one another or independently.

For copies of these documents or for information on gender-inclusive health planning or women's health issues, please contact the Women's Health Bureau at (250) 952-2256 in Victoria. Outside of Victoria, call Enquiry BC at (604) 660-2421 in Vancouver or 1-800-663-7867 elsewhere in the province, and ask to be connected to the Women's Health Bureau at (250) 952-2256.

INTRODUCTION

In December 1997, the British Columbia Ministry of Health and Ministry Responsible for Seniors published *Health Goals for British Columbia*, a document containing six goals which

> *. . . set out a vision and means for improving the health of the population and reducing health inequities by increasing awareness and understanding of the factors that truly affect our health, and by providing a framework that will enable people to work towards realising that vision. Health goals are a powerful tool for identifying health priorities and for linking policies and investment to these priorities.*

In this document, *Provincial Profile of Women's Health Issues: Updated Data on Selected Indicators*, the health goals and their corresponding objectives are used as a framework for providing women's health information. The primary purpose of this document is to assist health planners and health authorities in prioritizing women's health needs, and incorporating these issues into policy and program planning and resource allocation. Quantitative data are provided on selected indicators for four of the six health goals, as well data on an overall indicator, life expectancy. In addition, qualitative information is used to place the statistical information in the context of women's lives. Table 1 provides an overview of the four health goals and the selected women's health indicators.

Table 1: Four Provincial Health Goals & Selected Women's Health Indicators

HEALTH GOAL	WOMEN'S HEALTH INDICATORS
Positive and supportive living and working conditions	• Low income rate (Graph 2) • Income assistance rate (Graph 3) • Sexual assault rate (Graph 4) • Spousal assault rate (Graph 5)
Individual capacities, skills and choices	• Teenage pregnancy rate (Graphs 6&7) • Abortion rate (Graph 8)
Effective and efficient health service system that provides equitable access to appropriate services	• Percentage able to access abortion in their health region (Graph 9) • Hysterectomy rate (Graph 10) • Caesarean rate (Graph 11)
Reduction of preventable illness, injuries, disabilities and premature deaths	• Female mortality rate from ischaemic heart disease (Graph 12) • Female mortality rate from lung cancer (Graph 13) • Female mortality rate from breast cancer (Graph 14) • Potential Years of Life Lost (Graph 15)

The indicators selected are not intended to be an exhaustive inventory of women's health issues; rather, they are selected as examples to provide an overview of the diversity of women's health issues. The particular indicators are selected for the following reasons: they are relevant to women's health; health authorities and planners have expressed interest in these indicators; and quantitative data exist and will likely continue being collected to allow for comparison across time.

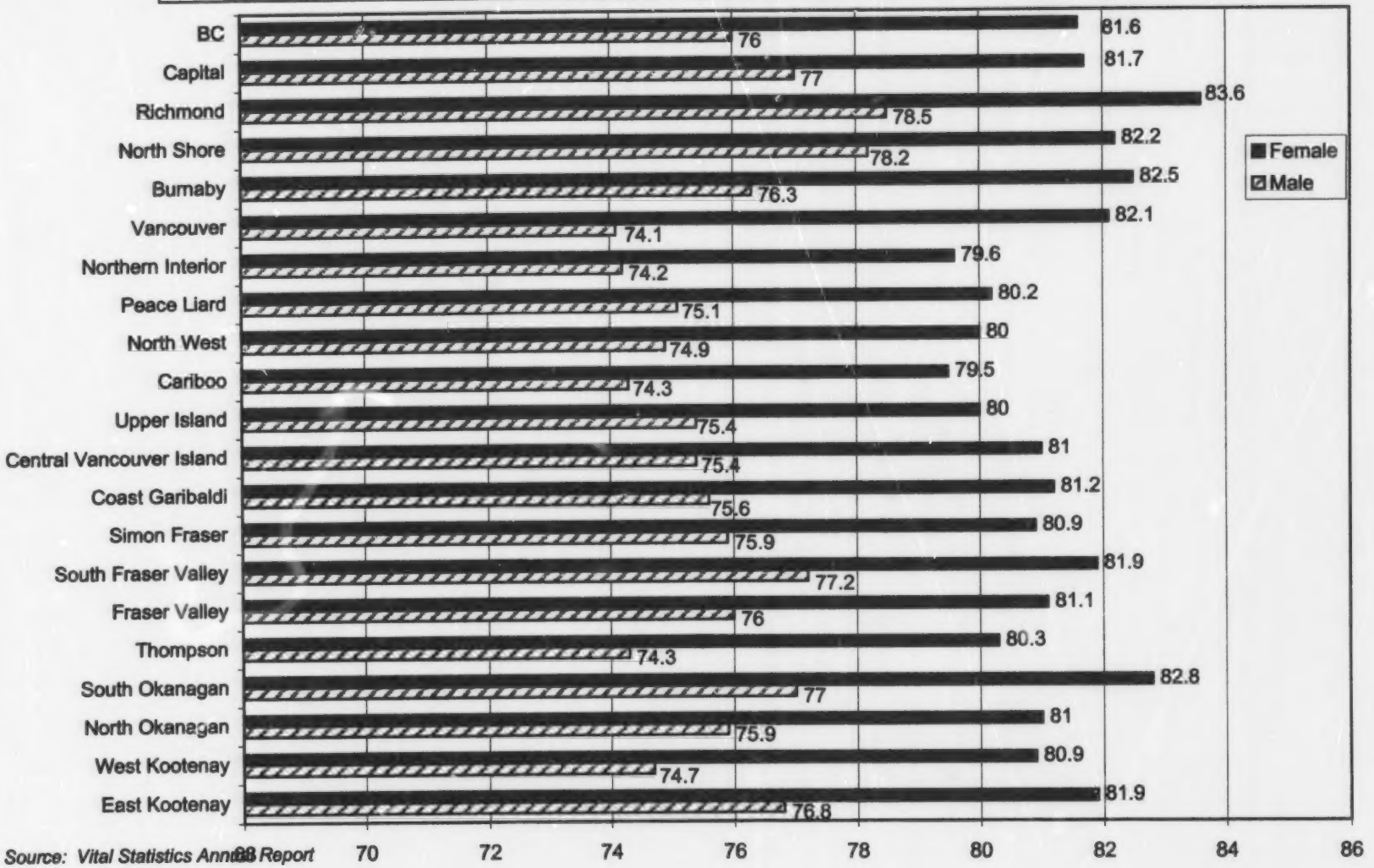
The indicators selected address a broad definition of health and are consistent with the population health approach. Broadly defined, women's health comprises more than physical health. It includes emotional, social, cultural and spiritual aspects; and is intricately related to the social, political and economic context of women's lives. A population approach to health examines factors, such as income and social conditions that influence the health of population groups.

The population approach to health recognizes that different population groups have varied access to the factors that contribute to health, and that these factors are not equally distributed. For example, socioeconomic status is positively associated with health status; however, in comparison to men, women still receive less pay on average for the same work and more often live in poverty. Women are also more often victims of violence and are under-represented in decision-making bodies, compared to men. These factors are compounded by the fact that women experience more and different barriers to health care than men and, despite longer life expectancy (**Graph 1: Life Expectancy in British Columbia, 1994 to 1998**), suffer more ill health during their life-span than men. Women also use the health care system twenty-five percent more often than men. Consequently, gender is regarded as one determinant of health because being male or female to some extent determines future health.

Any measure of women's health must also take into the consideration the diversity of women. Women are not a homogeneous group; they often have very different experiences of health, illness and health care, and have different access to the conditions that contribute to health and well-being. For example, according to data on life expectancy (**Graph 1: Life Expectancy in British Columbia, 1994 to 1998**), BC women enjoy a standard of health that is among the best in the world. However, not all groups of BC women enjoy this same standard. For example, women in urban areas live four years longer on average than women in rural and northern areas. Also, Aboriginal women have an average life expectancy twelve years less than that of non-Aboriginal women.

While quantitative data provide useful information for planning and monitoring, it must be viewed in the appropriate context. Qualitative data sources, such as local women's centres, also contribute valuable information on women's health issues. Health authorities and health planners are encouraged to consult other sources of data related to women's health. In addition, more detailed statistics will be available soon through the Ministry of Health Data Warehouse. The Health Data Warehouse, currently in test mode, has indicators linked to the Provincial Health Goals.

Graph 1: Life Expectancy in British Columbia, 1994 to 1998



Source: Vital Statistics Annual Report

GOAL ONE: POSITIVE AND SUPPORTIVE LIVING AND WORKING CONDITIONS

Poverty and Health

Poverty is associated with a number of conditions that adversely affect health and limit access to health care, including poor housing conditions, behavioural problems, isolation and depression. Research has found that people who are living in conditions of lower socioeconomic status as measured by income, education or occupational status, are more likely to:

- experience disease, disability and early death;
- work in dangerous, stressful or unstable jobs;
- live in unsafe or unhealthy homes and neighborhoods, spending relatively high proportions of their income on housing that may be temporary; and,
- have less social support and fewer social networks.

These conditions in turn are associated with an increased risk of disease as a result of high blood pressure, high cholesterol levels and the release of stress hormones. Persons who are socially isolated are at greater risk of disease and death.

People living in poverty are also more likely to:

- engage in health damaging behaviours, such as smoking or substance abuse; and
- experience obstacles to obtaining basic health care services, such as lack of transportation, difficulty in arranging child care or time off work to attend appointments, and the expense of medication.

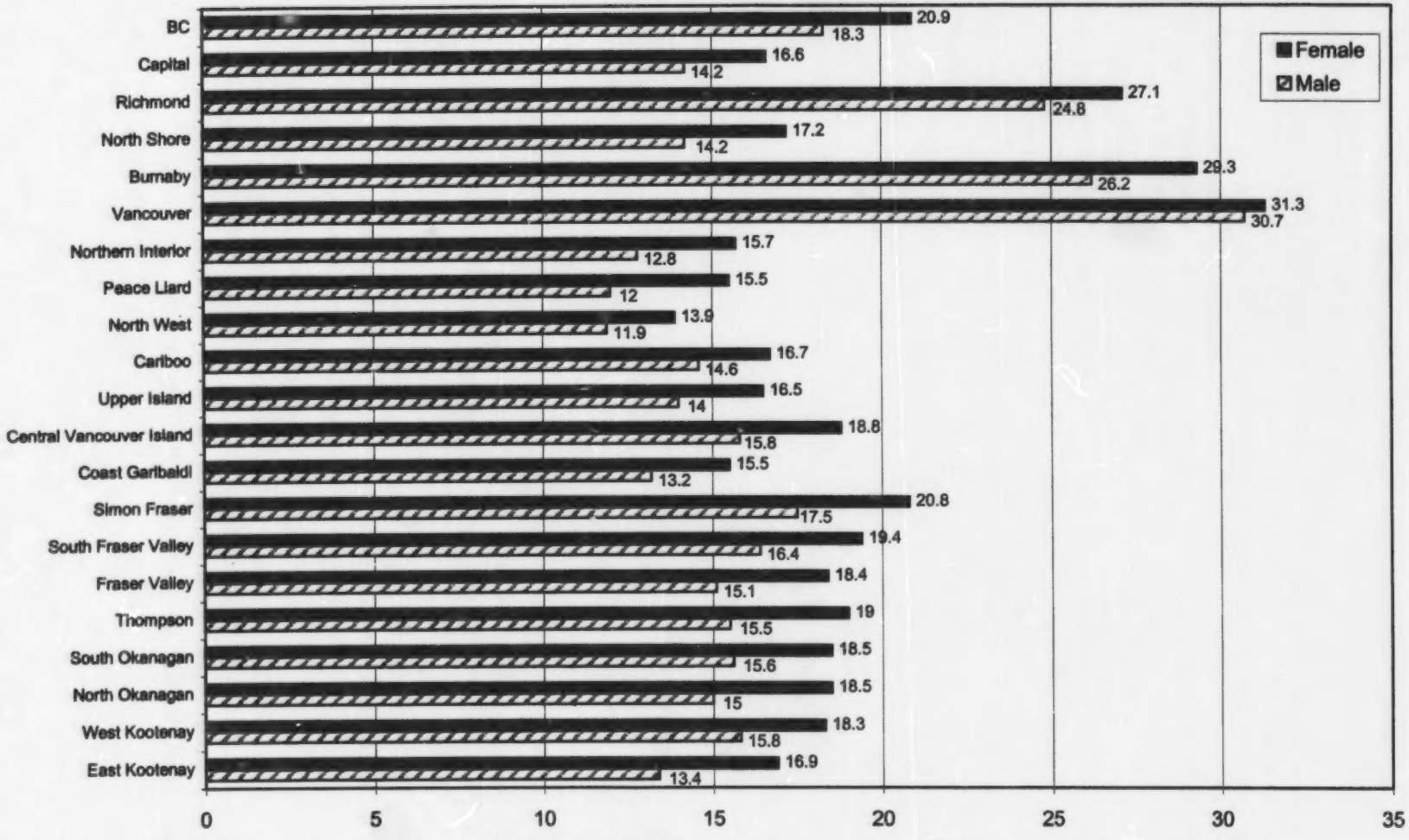
Given the multiple effects of poverty, it is not surprising that it is also associated with poor health status and certain population groups, such as women, are more susceptible to poverty.

Employed women working full-time, year-round in BC earn 73 percent of what men earn. Women are also more likely to work part-time. In every region of BC, more women than men fall below the Statistics Canada Low Income Cut Off (LICO). A person or family is considered to be below the LICO if 70 percent of their income is used to buy food, clothing and shelter (**Graph 2: Percentage of People with Low Incomes by Gender and Health Area, 1996 Census Data**).

Consequently, more women require income assistance to maintain a minimal standard of living. With the exception of the Vancouver/Richmond and Capital Health Regions, more women than men between the ages of 19 and 64 receive income assistance from the provincial government (**Graph 3: Percentage Of Males And Females Aged 19 To 64 Receiving Basic BC Benefits, September 1999**).

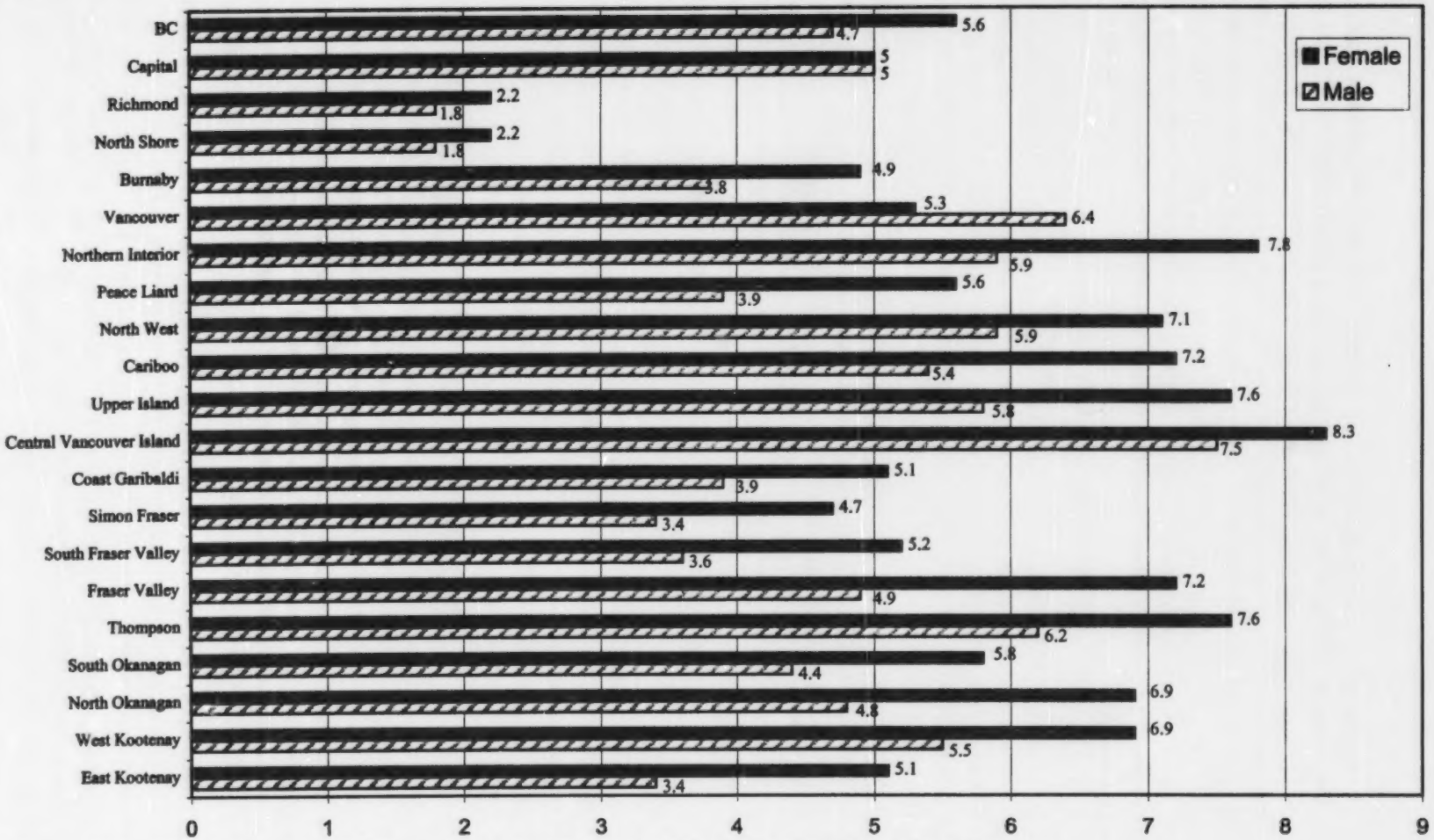
The relationship between poverty and health is complex due to the many and varied socioeconomic problems related to poverty. The links between the social and economic environment are particularly important for women, who have lower incomes on average and receive income assistance more often. The stress of living in poverty and receiving income assistance can affect both the physical and mental health of women and their families. Health boards and councils should be aware of these factors and effects as they plan to address the health needs of designated populations.

Graph 2: Percentage of People with Low Incomes by Gender and Health Region, 1996 Census Data



Source: Statistics Canada, 1996 Census of Canada, custom tabulation GO0199. Compiled by Information and Analysis Branch, BC Ministry of Health

Graph 3: Percentage Of Males And Females Age 19 To 64 Receiving Basic BC Benefits, September 1999



Source: Ministry of Social Development & Economic Security, Administrative Files and BC STATS Population Estimates

Violence and Health

When women are asked about their most pressing health concerns, violence often tops the list. Nevertheless, violence has traditionally been viewed as a justice issue rather than a health issue. This perception is erroneous, since the cost of violence to the Canadian health care system is estimated at $4 billion per year. In BC alone, the cost is measured at $400 million per year. The indirect costs to the health care system, such as increased physician visits for complications resulting from stress, have yet to be calculated.

Although both men and women experience violence, women are far more likely to experience certain types of violence, such as sexual assault and assault by an intimate partner. Violence against women occurs in many different forms, including harassment, sexual abuse, financial and psychological abuse, and physical violence. All forms of violence significantly affect all aspects of health—mental, spiritual, physical and emotional.

Not surprisingly, women who experience violence use a greater proportion of health care services than do non-abused women. Several long-term physical health problems are associated with those who experience violence:

- arthritis;
- chronic pain;
- hearing loss;
- sexually-transmitted diseases;
- chronic bowel problems;
- pelvic inflammatory disease; and,
- neurological damage.

In BC, 59 percent of women have experienced at least one incident of physical or sexual violence since the age of 16. BC ranks first when compared to other provinces in Canada for recorded incidents of violence against women; one in two women are victims of sexual assault, one in three of wife assault, and one in five of other types of physical assault (Ministry of Women's Equality, 1998).

Sexual Assault

According to the Violence Against Women Survey in 1995, 39 percent of Canadian women have experienced at least one incident of sexual assault since the age of 16. In 1998, a total of almost 5,000 sexual assaults and other sexual offences were reported to police in BC Eighty-seven percent of the sex crimes reported were classified as Level 1 sexual assault, defined as any form of forced sexual activity without bodily harm. Two percent were classified as Level 2 sexual assaults, which occur when someone uses or threatens to use bodily harm or a weapon in the course of a sexual assault. Level 3 sexual assaults, which occur when a person wounds, maims, disfigured, beats or endangers the life of a person during a sexual assault, accounted for 1 percent of the sexual offences. Of those charged with sexual offences in 1998, 98 percent were male (**Graph 4: Total Sex Offences Per 1,000 Population That Were Reported to Police By Health Area, 1998**).

Relatively few assaults are ever reported to the police—only an estimated 6 percent. It is therefore important to recognize when viewing the statistics on the incidents of sexual assault in BC that the reported incidences represent only a fraction of the actual numbers of sexual assaults that take place.

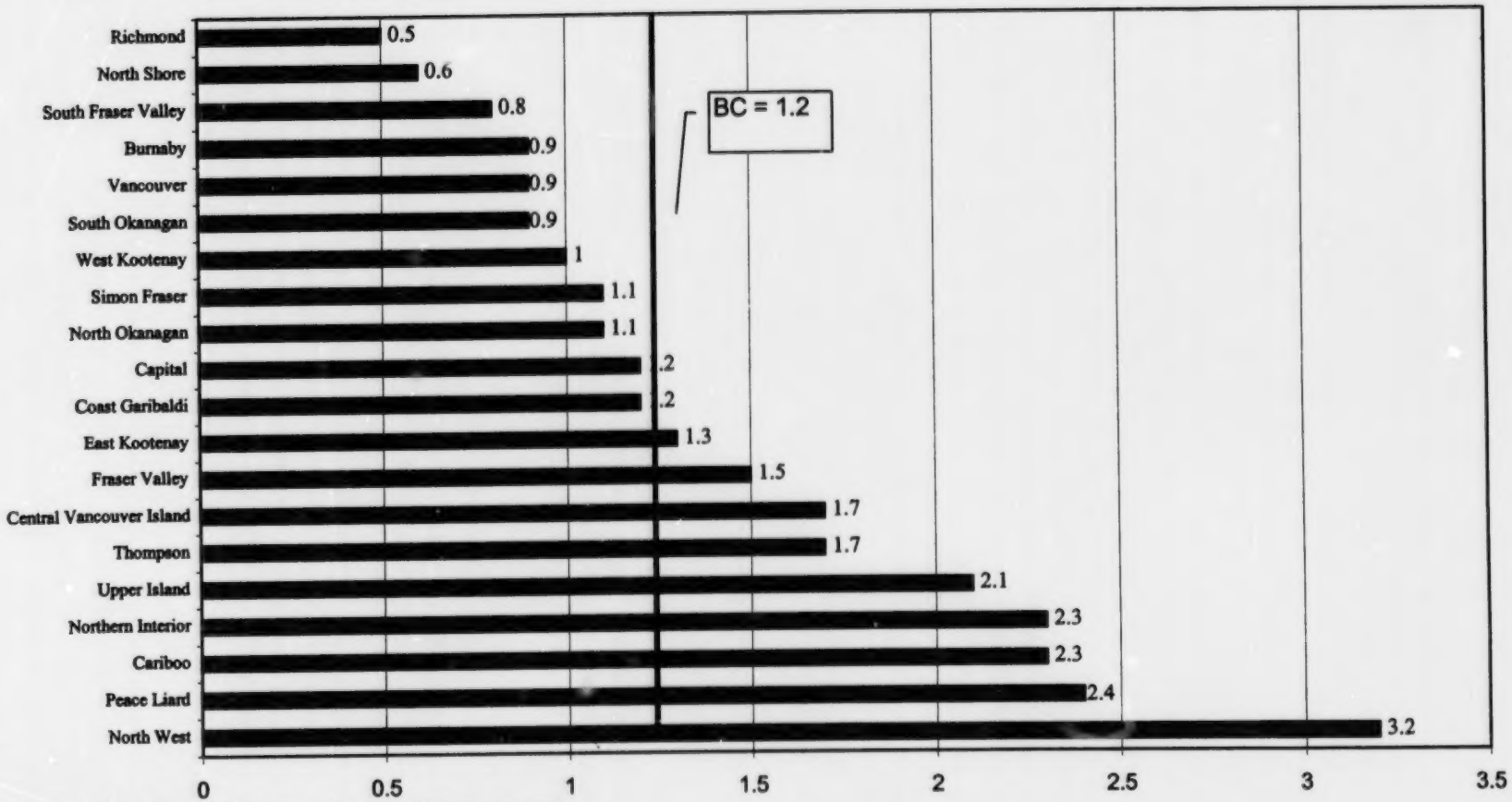
Assault By an Intimate Male Partner

In Canada, at least one in eight women is physically and/or sexually assaulted by her husband or male partner. The statistics reveal that women are 13 times more likely to be abused in their own home by their partner than by a stranger on the streets. Compared to other Canadian provinces, BC has one of the highest rates of reported assault by an intimate male partner (**Graph 5: Rate Per 1,000 Population of Spousal Assaults Reported to Police by Health Area, Annual Average for 1996 to 1998**). Importantly, many cases of intimate-partner assault go unreported because of factors such as fear of reprisal by the assailant. On average, women are assaulted up to eight times before a report is filed with the police.

Of the 9,500 reported incidents of spousal assault in BC in 1998, 81 percent involved a male offender, 9 percent involved a female offender, and 10 percent involved both spouses assaulting each other. Almost 50 percent of all spousal assault incidents were alcohol-related.

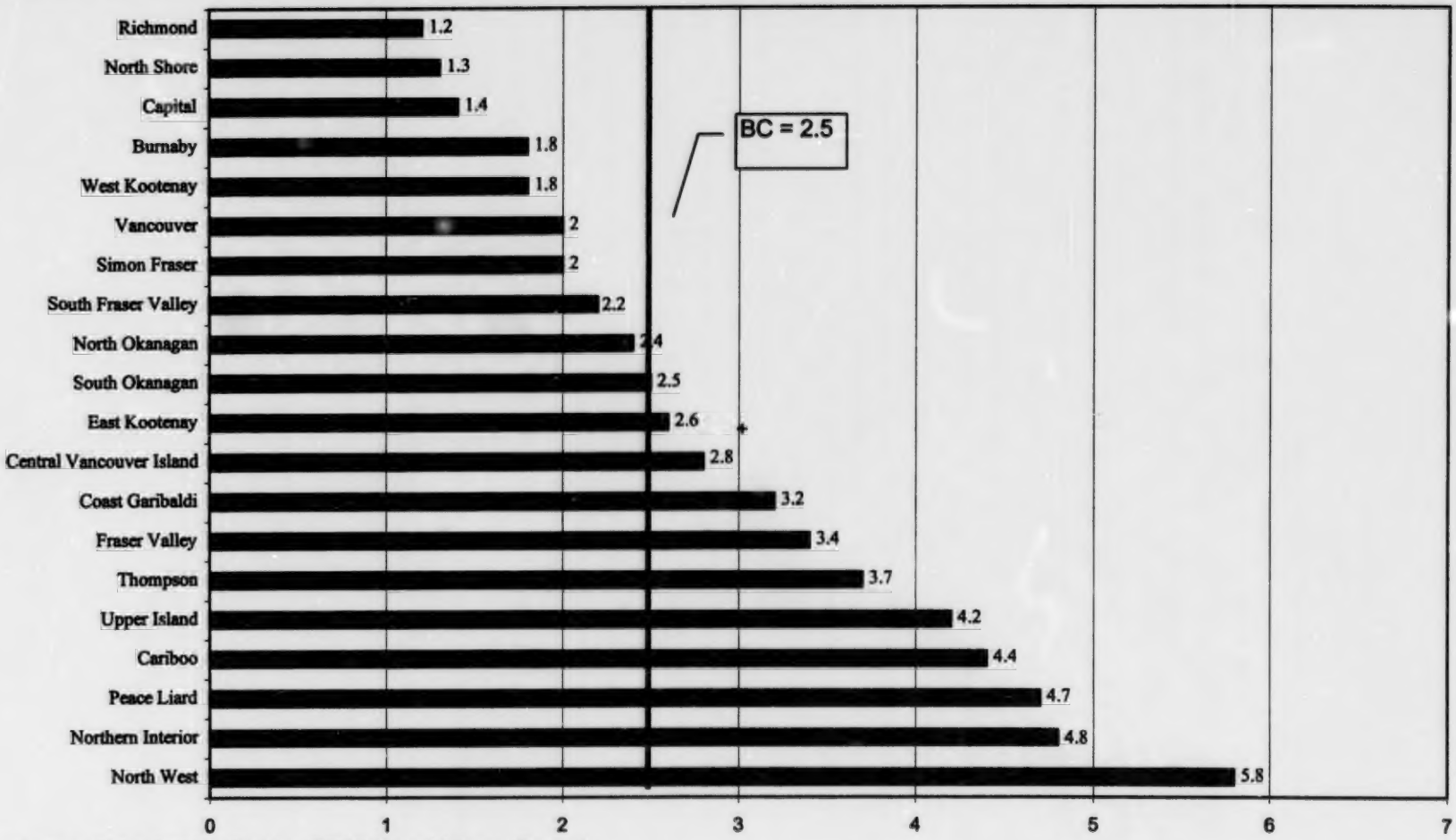
In summary, eradicating violence is crucial to the health of women and their families. The physical, emotional, social, and economic costs of sexual and physical violence against women have been recognized as a primary health concern. Women who have experienced violence have more contact with the health care system, both for physical care as a direct result of violence, and/or for related but indirect health care (e.g., hearing loss, gastrointestinal conditions, etc.). The health care system is often the first place where a woman comes in contact with a professional and has the opportunity to disclose her situation or seek support. For women who have been sexually assaulted, emergency health care may be their first point of contact for assistance. Given the impact of violence on women's health and the health care system, it is recommended that health planners develop an integrated response with the network of services that already exist to support and protect women who experience violence.

Graph 4: Total Sex Offences Per 1,000 Total Population That Were Reported To Police By Health Region, 1998



Source: Police Services Division, Ministry of Attorney General
Prepared By: Women's Health Bureau, BC Ministry of Health and Ministry Responsible For Seniors
Note: Total Sex Offences Includes Sex Assault-Level 1, Sex Assault-Level 2 (Weapon/Bodily Harm), Sex Assault-Level 3 (Aggravated) and Other Sexual Offences such as sexual interference, invitation to sexual touch, sexual exploitation and incest

Graph 5: Rate Per 1,000 Population of Spousal Assaults Reported To Police by Health Region, Annual Average for 1996 to 1998



Source: Police Services Division, BC Ministry of Attorney General
Prepared By: BC STATS, BC Ministry of Finance and Corporate Relations

GOAL TWO: INDIVIDUAL CAPACITIES, SKILLS AND CHOICES

Reproductive Health

Reproductive and sexual health is one area where it is imperative that women have access to unbiased information to develop capacities and skills for making informed choices. Comprehensive reproductive health recognizes that women across the life-span have special needs and rights in relation to reproduction and sexuality. For example, teens need information about issues such as sexuality and unintended pregnancy; women in their child-bearing years need information about fertility and childbearing; and women in mid-life and beyond need information about the natural changes that occur throughout the ageing process and their impact on sexuality and the reproductive system.

For teens, information on safe sex practices is an important component of preventing unintended pregnancies. Early teenage childbearing is of particular concern, often beginning a cycle of poverty and dependence on social assistance. In addition, birth outcomes are generally poorer when the mother is a teen. Babies born to teenage mothers usually have lower birth weights and are more susceptible to illness and Sudden Infant Death Syndrome. Because many teen pregnancies are unintended and birth outcomes are generally poorer among teen mothers, it is important that reducing teen pregnancy rates be a priority. Methods to accomplish this include sex education and better access to contraceptive clinics. The myth still persists that sex education leads to promiscuity; however, the opposite has proven true. It has been repeatedly shown that sex education leads to responsible behaviour, higher levels of abstinence, later initiation of sexuality, more frequent use of contraception and fewer sex partners. A combination of reproductive health education and the availability of contraceptive clinics can substantially reduce teen pregnancy, abortions and births (**Graph 6: Teenage Pregnancies Rate Including Live Births, Stillbirths, Induced Abortions, and Miscarriages Resulting in Hospitalizations, Ages 15 to 19, by Health Area per 1,000 Women, 1998/99**).

The teenage pregnancy rates in BC have been gradually decreasing—from 49.7 per 1,000 females in 1990/91, to 40.0 per 1,000 females in 1998/99 (**Graph 7: Teenage Pregnancy Rate Ages 15 to 19 for British Columbia, 1990/91 to 1998/99**). This declining trend can be seen in most of the health regions. However, the decrease is less evident in a few of the health regions, including Peace Liard, Northern Interior, Burnaby, North Shore and Capital.

A comprehensive approach to reproductive health is the recognition that women have the right to control the timing and spacing of their pregnancies, and the right to affordable, safe and accessible birth control information, products and services. Reproductive health also supports women's right to choose whether to continue a pregnancy to term, or to access abortion services without harassment.

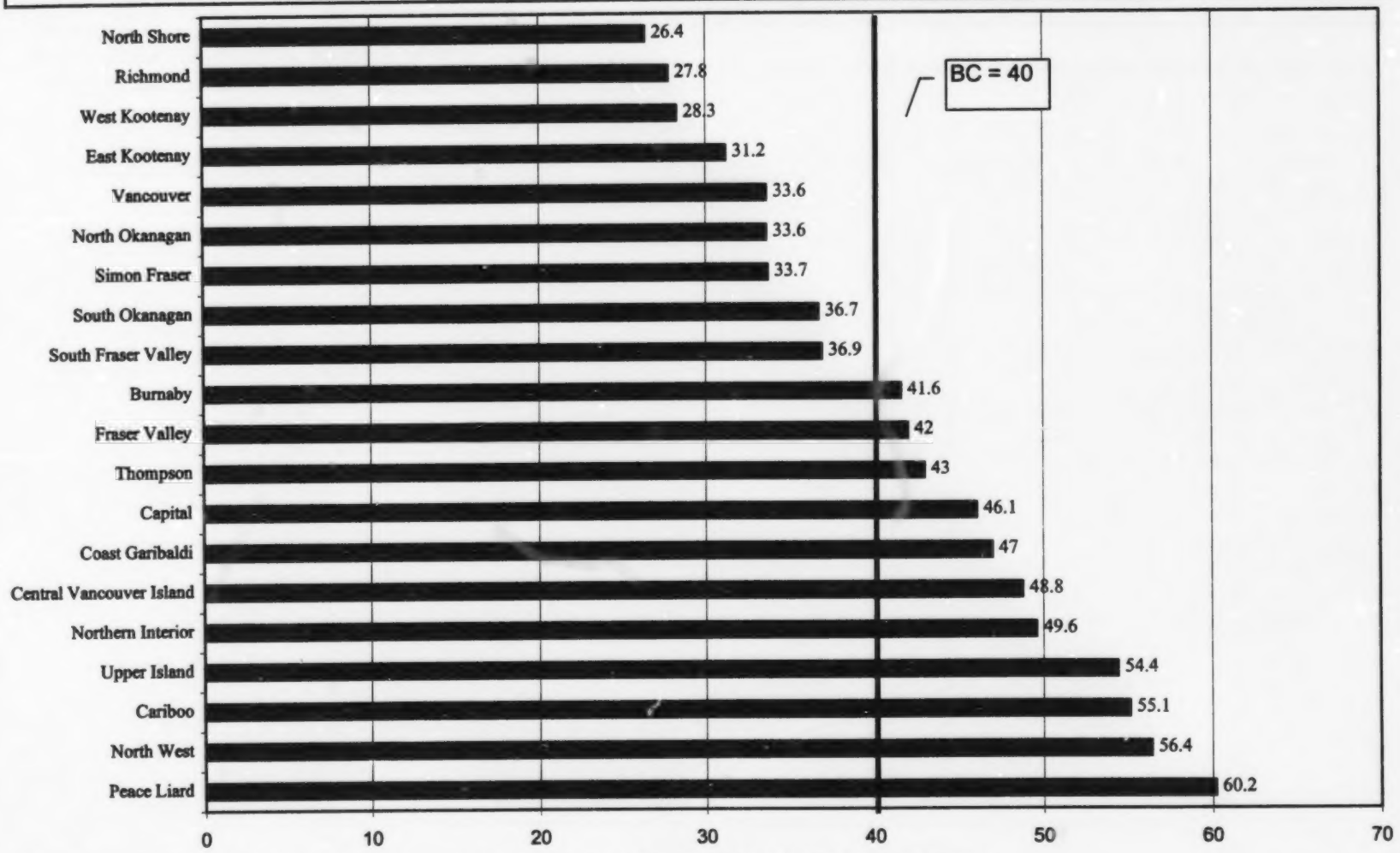
The option of not continuing a pregnancy to term:

- is consistent with BC's policy that abortion is a legal and medically required service;
- supports the Supreme Court Ruling that deemed unconstitutional the section of the Criminal Code that made abortion illegal; and,
- supports the Canada Health Act (1994), which embodies the principles of accessibility, universality, portability, comprehensiveness and public administration.

Abortion rates provide an indirect measure of unintended pregnancy and information on access to and use of contraception. That a significant number of women experience unintended pregnancies is indicated by the fact that approximately one in five pregnancies ends in abortion. Unintended pregnancies occur at all ages, but the majority of women who have abortions are in their early twenties. Women aged 20 to 24 are three times more likely to have an abortion than women in their early and late thirties. Studies show that countries such as the Netherlands that have full access to contraception and abortion, combined with comprehensive sex education programs, have lower abortion rates than countries where abortion is illegal or inaccessible. Given the evidence, it is important to ensure that women in BC are provided with the information and services to assist them in controlling their reproductive health (**Graph 8: Abortion Rate Per 1,000 Women, Ages 15 to 44, 1998/99**).

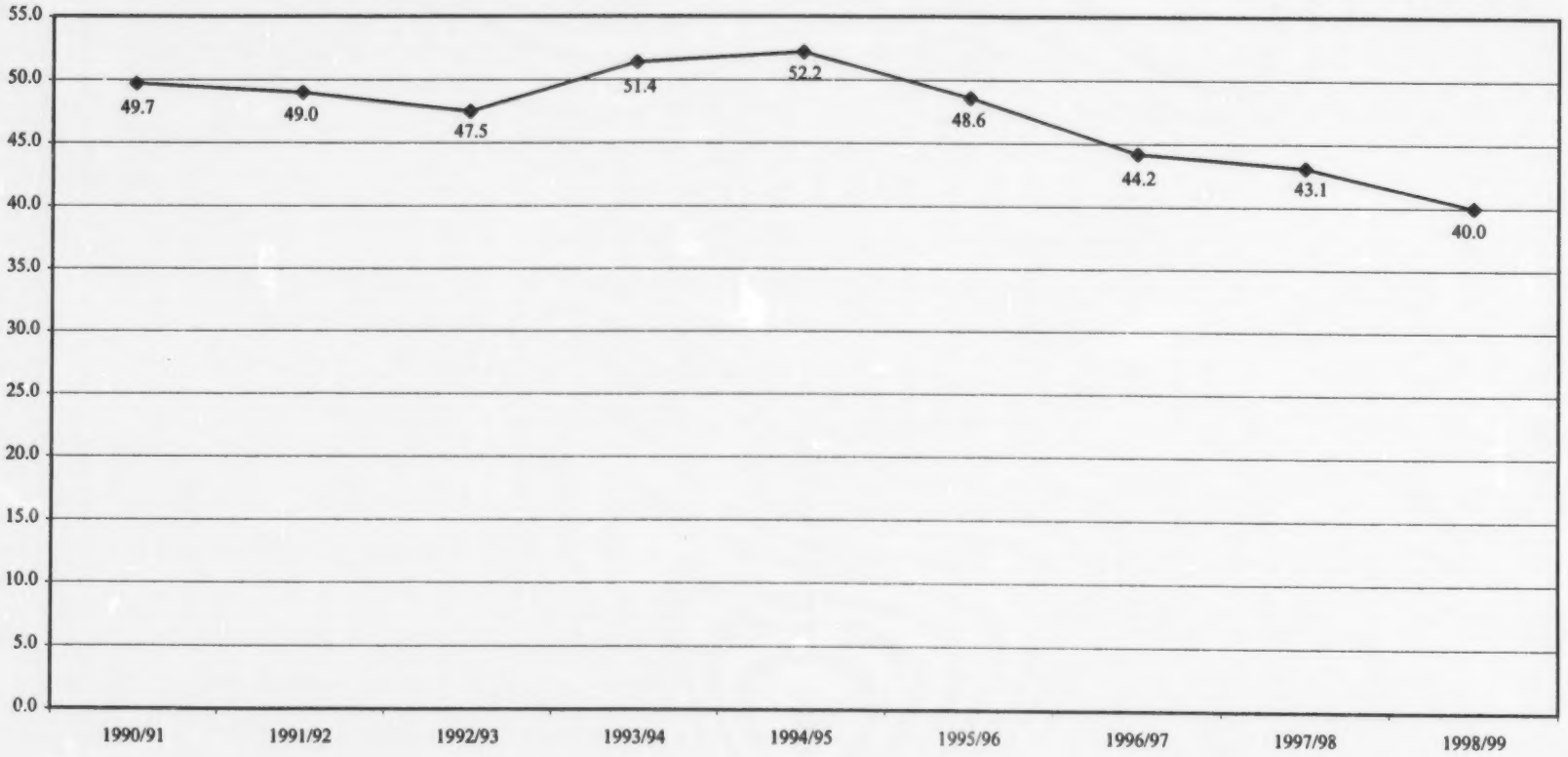
Important components of reproductive health are that people have access to the knowledge and resources to enable them to have a responsible and safe sex life; and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (World Health Organization). By many standards, women in BC enjoy a high level of reproductive health. However, many women experience unintended pregnancies, sexually-transmitted diseases and reproductive tract infections. While not all problems can be prevented, many can be through education and access to services and products. Health planners and authorities should be aware of the barriers women face to obtaining reproductive health information and services in their communities.

Graph 6: Teenage Pregnancy Rates, Including Live Births, Stillbirths, Induced Abortions, and Miscarriages Resulting in Hospitalizations, Ages 15 to 19, By Health Region Per 1,000 Women, 1998/99



Source: Pregnancy Counts and Rates By Age Groups By Health Region, British Columbia, BC Vital Statistics Agency

Graph 7: Teenage Pregnancy Rates (Ages 15 to 19) for British Columbia, 1990/91 to 1998/99

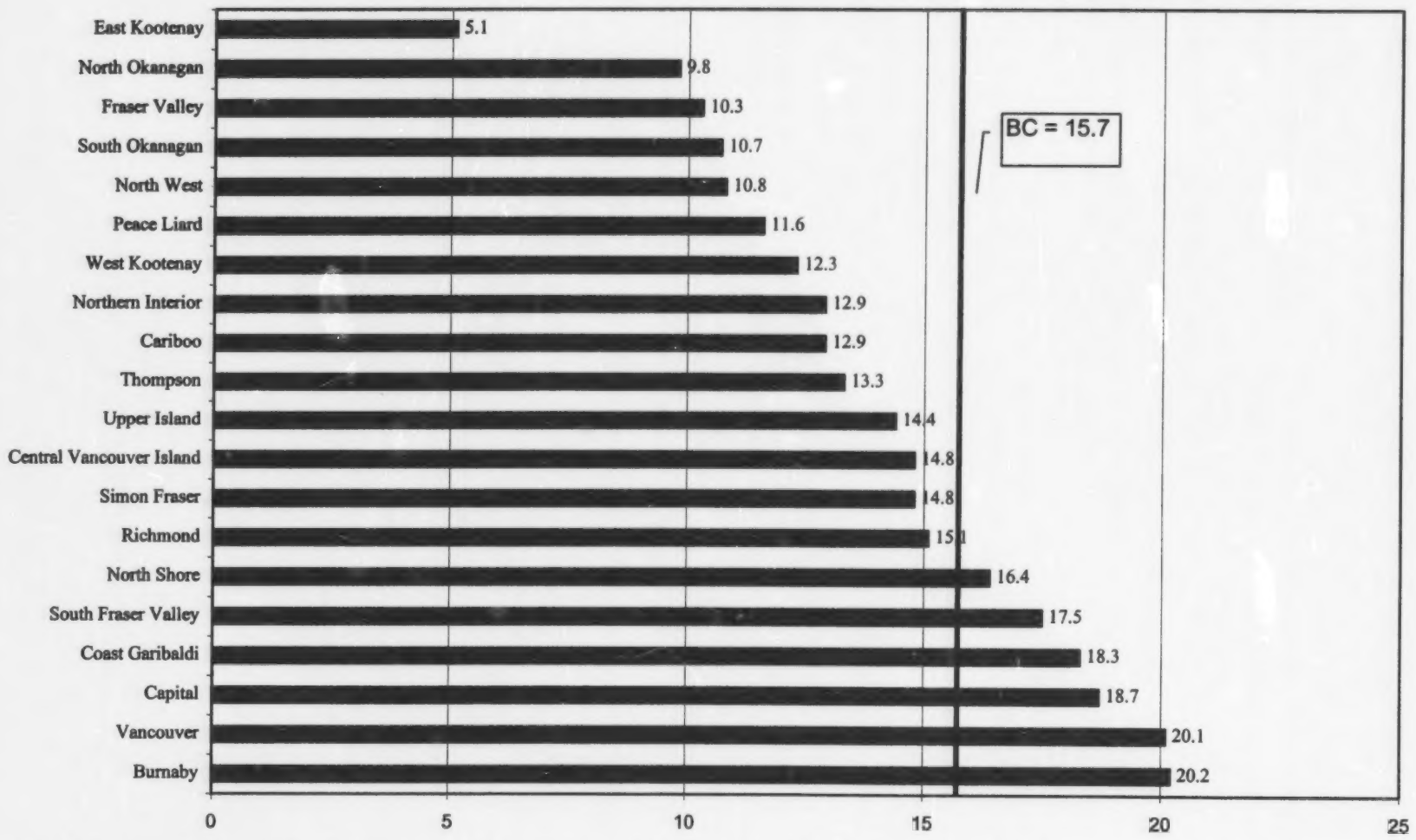


Source: BC Vital Statistics Agency, Unpublished Tables

Note: *Pregnancy rates per 1,000 females ages 15-19. Pregnancies include live births, stillbirths, induced abortions ,and miscarriages resulting in hospitalizations. Multiple births are counted as one pregnancy.*

The apparent increase in rates in 1993 reflects the inclusion of data on therapeutic abortions performed in freestanding clinics in the Lower Mainland. These clinics were established in the late 1980s. Beginning with the 1993/94 fiscal year, clinic summary data are being merged with hospital statistics in order to provide a more complete picture of pregnancy outcomes in BC.

Graph 8: Abortion Rates Per 1,000 Women, Ages 15-44, 1998/99



Source: Pregnancy Counts and Rates By Age Groups By Health Region, British Columbia. BC Vital Statistics Agency, 2000

GOAL FOUR: EFFECTIVE AND EFFICIENT HEALTH SERVICE SYSTEM THAT PROVIDES EQUITABLE ACCESS TO APPROPRIATE SERVICES

Equitable access to appropriate health services is an essential part of effective health care. Because women use the health care system 25 percent more than men, it is important that services be available and appropriate to meet women's health needs. Equitable access and women's health often present a paradox. Access to some services and products is limited, notably in the area of reproductive health. On the other hand, services, products and pharmaceuticals are often over-used, resulting in inappropriate treatment or "over-medicalization" of women's health care.

Reproductive health is one area where women face barriers to accessing legally available, medically required health services. Women should be able to obtain health care services in their own community, which is not always the case when dealing with reproductive health concerns. Abortion is one service where access varies widely across BC. A community's ability to provide abortion services to its own residents is one indicator of accessibility. A large number of women travelling out of their residential area to receive abortion services may indicate either problems with access, or a perceived or real lack of confidentiality.

Women living in the southern interior of BC have limited access to abortion services within their own communities — only 1-7 percent are able to obtain services in their own health authority area. The health areas surrounding the lower mainland have a low percentage of women receiving abortion services in their own community. Because services are readily available in Vancouver, however, these women do not face as many geographical barriers as those women living in northern and rural parts of BC.

Although some health areas have high percentages of women receiving abortions in their regions, this does not necessarily mean services are readily accessible. Due to the size and geography of some regions, women might have to travel long distances even within their own health area to obtain service.

In addition, some health care facilities in the province are not providing abortion services to women in their health authority area, even if they have the capacity to do so. Since abortion is considered a legally mandated service in BC, abortion services must be readily available to all women within the province regardless of individuals' views of abortion. **(Graph 9: Percentage of Women Who Are Able to Access Abortion Within Their Own Health Area, 1998/99)**.

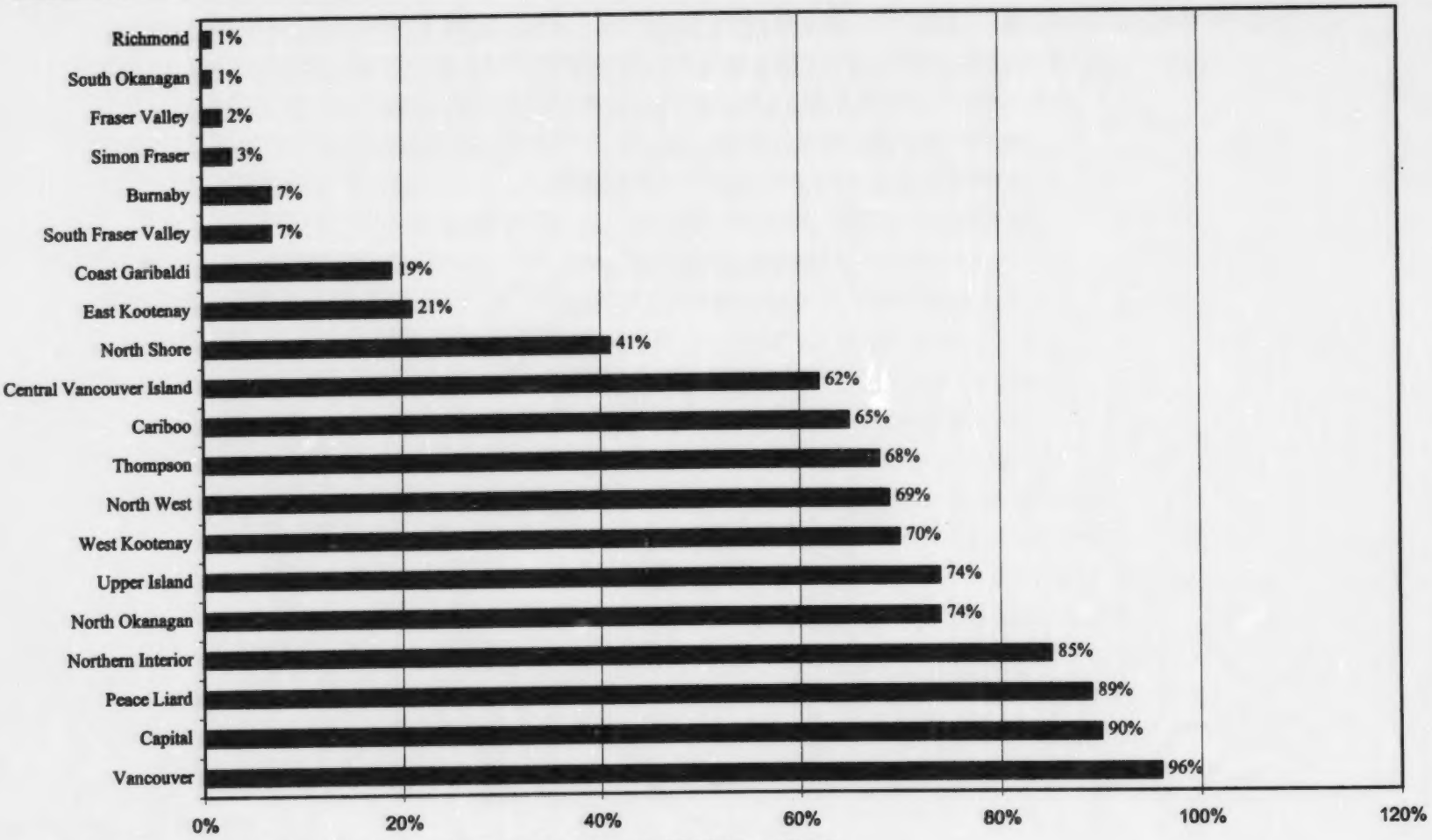
Advocates have long been concerned that the biomedical model of health care has led to over-treatment of women with certain health concerns. The biomedical model, the dominant approach to health care in Canada today, is based on technological and pharmacological interventions focused on, but not limited to, hospitals, physicians and pharmaceuticals.

Over-medicalization of women's health refers to situations where treatment relies too heavily on highly technological interventions when a less invasive or aggressive approach would be of similar or greater benefit, and when the medical approach is applied to situations that are not fundamentally "treatment" issues.

Because women use the health-care system more frequently than men, they are at greater risk of receiving services that are inappropriate and unnecessary. Over-medicalization has physical, mental and emotional consequences related to both the procedures themselves (tests, medications, surgeries, etc.) and to the consequences on women's lives (time away from work, lack of home support during recovery, etc.). Research has shown that medical procedures such as hysterectomies (**Graph 10: Hysterectomy Rate per 1,000 Women Aged 20+, Age Standardized, 1998/99**) and caesarean sections (**Graph 11: Caesarean Section Rate per 100 Live Births by Health Area, 1998**) are performed at higher rates in some areas than necessary. While these procedures are clearly appropriate in some cases, they should not be done unnecessarily. It is important for the health care system to provide women with the information to make informed choices about medical procedures and available alternatives.

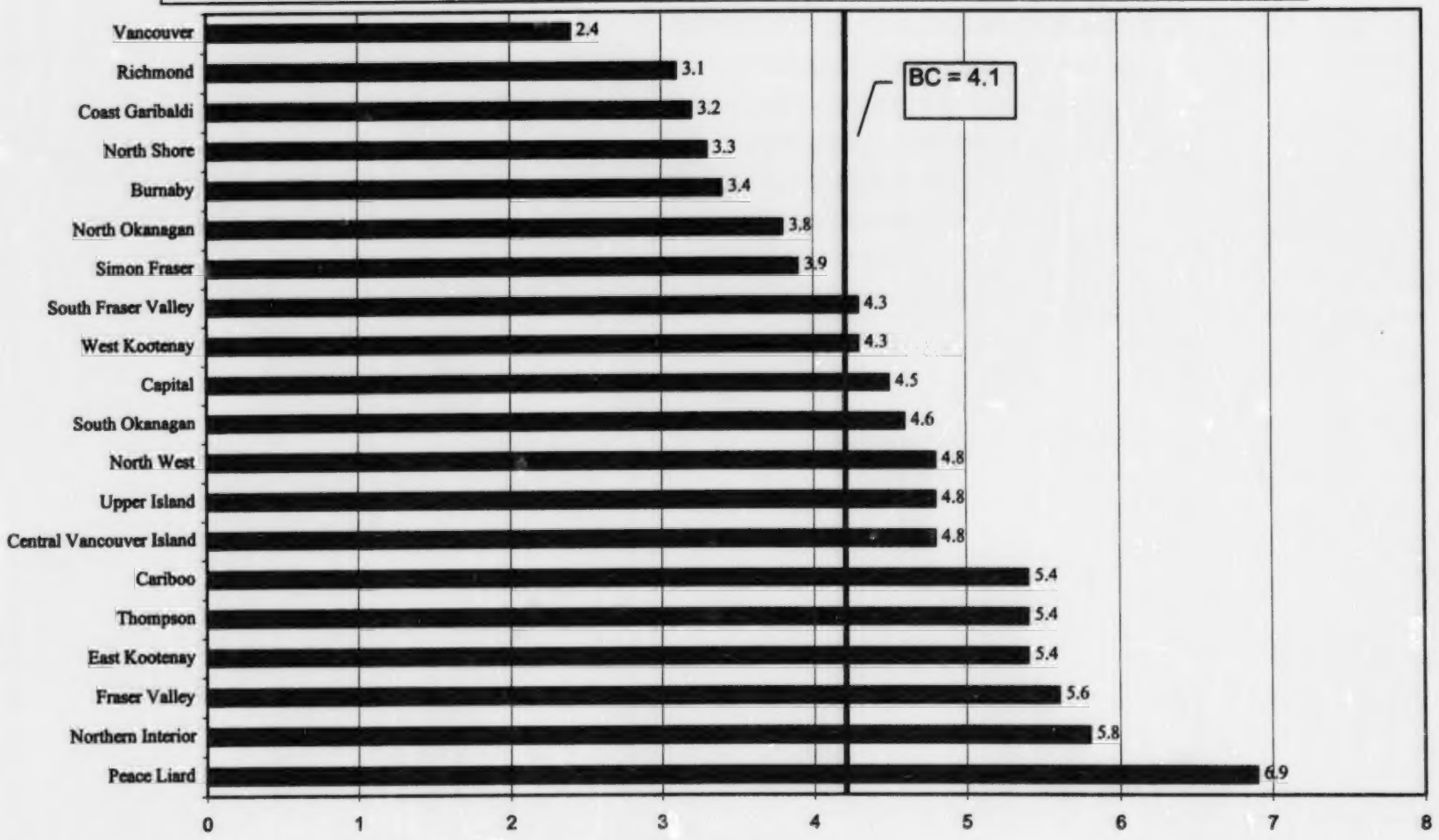
Equitable access to appropriate services is essential for effective health care in BC. Since women have more contact with the health care system, it is important that services be appropriate and available to meet their specific needs. It is recommended that health authorities and planners work towards ensuring the provision of necessary services for women in their communities. They should also identify ineffective and inappropriate services and re-allocate health care dollars to more effective services and prevention and health promotion activities.

Graph 9: Percentage Of Women Who Are Able To Access Abortion Services Within Their Health Region, 1998/99



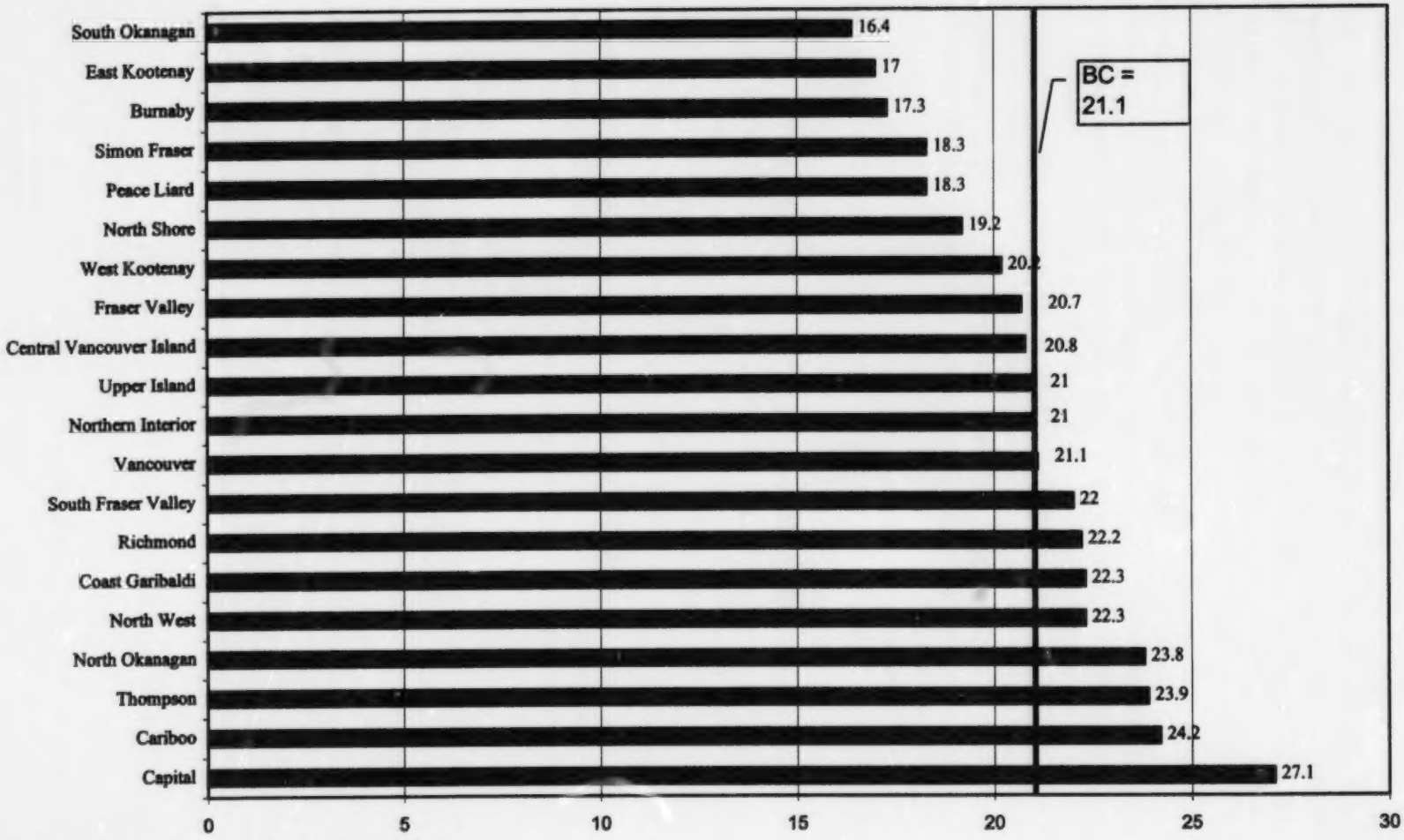
Source: Local/ Regional Referral Analysis, Information and Analysis Branch, BC Ministry of Health

Graph 10: Age Standardized Hysterectomy Rates Per 1,000 Women Aged 20+, 1998-99



Source: Information and Analysis Branch, BC Ministry of Health

Graph 11: Caesarean Section Births Per 100 Live Births by Health Region, 1998



Source: BC Vital Statistics Agency, Unpublished Tables

GOAL SIX: REDUCTION OF PREVENTABLE ILLNESS, INJURIES, DISABILITIES AND PREMATURE DEATHS

Illness and Premature Deaths of Women

Women in BC live longer than men and are more likely to experience age-related disabilities, injuries and illnesses. Women's longer life expectancy is associated with longer periods of living with disease and coping with some degree of dysfunction.

Cardiovascular disease (CVD) is the leading cause of death among women in BC. CVD is a broad category of conditions that affect the heart and bloodstream, the most common type being ischaemic or coronary heart disease, where the heart muscle function is impaired by a reduced blood supply. Although death rates have declined in recent years, ischaemic heart disease still ranks as the number-one cause of death for women. Several factors place women at risk for this disease, such as smoking, high blood pressure, physical inactivity, obesity and diabetes. These risk factors are more prevalent as women age. The greater the number of risk factors a woman has, the more she should be concerned about prevention. Women need to be aware of the risk of heart disease and begin at an early age to take charge of their own heart health (**Graph 12: Female Mortality Rate From Ischaemic Heart Disease per 10,000 Women by Health Area, Age Standardized, 1998**).

Since CVD has traditionally been considered primarily a "man's disease", the health care system has only recently begun to address the issue of women's heart health. It is becoming more widely accepted that women experience heart disease differently than men — including initial symptoms, time lapsed before they contact a health care professional, and reaction to treatment. Much more needs to be done to address this number-one killer of women in BC.

Cancer is the second leading cause of death among women in BC. Although there are many forms of cancer, lung cancer is the number-one cause of cancer death among women. The rate of survival after a diagnosis of lung cancer is very low. Fifteen percent of the affected population will recover from this disease. The chance of recovering from lung cancer remains low because there is no effective test to diagnose the disease at an early stage and few treatments are available for advanced lung disease. Once diagnosed with lung cancer, more than 80 percent of patients die within five years. Lung cancer is a largely preventable disease since the main cause is cigarette smoking. Although the effects of tobacco are well known, more than one in five women smokes in BC. The U.S. Cancer Research Institute reports that smoking is responsible for 85 percent of lung cancer deaths. The effects of smoking on women are significant, especially since there is evidence that women are two or three times more susceptible to the cancer-causing effects of tobacco smoke than men. Since lung cancer is directly linked to smoking, prevention efforts must focus on eliminating tobacco use among women and men (**Graph 13: Female Mortality Rate From Lung Cancer per 10,000 Women by Health Area, Age Standardized, 1998**). To address the issue of tobacco use among women, the differences between women and men must be understood and used to guide program planning and delivery.

For example, women smoke for different reasons than men, are more susceptible to addiction, are more physiologically vulnerable to the toxic effects of smoke, and need different support strategies for quitting. Therefore, it is imperative that smoking cessation programs recognize issues of gender in their program content and method of delivery.

Although lung cancer is the most common type of cancer death, breast cancer is the most commonly diagnosed cancer among women. This is partly because of early diagnosis through screening mammography. Women aged 50 and over are most at risk for developing breast cancer, and are encouraged to be screened through the Screening Mammography Program every two years (**Graph 14: Female Mortality Rate From Breast Cancer per 10,000 Women by Health Area, Age Standardized, 1998**). Although it is not yet known how to prevent breast cancer, appropriate use of screening mammography increases the likelihood of detection, thus allowing for earlier medical intervention at a stage of the disease where a cure is more likely.

The Potential Years of Life Lost Standardized Rates (PYLLSR) can be used as a health status indicator and examines the impact of premature deaths on the years of life which have been lost due to disease and fatalities (**Graph 15: Potential Years of Life Lost Standardized Rate for Females per 10,000 Standard Population by Health Area, All Causes of Death, 1998**).

Unlike many other health status indicators, there is no clear regional pattern among the four mortality indicators presented in this section. Northern, rural, and urban health regions are found at the high and low ends of the range in mortality rates. There are many possible reasons for the variations between the regions for these diseases. They include:

- effects of pollution, such as water and air contamination;
- demographics, such as age, of the population of a particular area; and,
- socioeconomic factors, such as poverty, housing, nutrition, alcoholism and smoking.

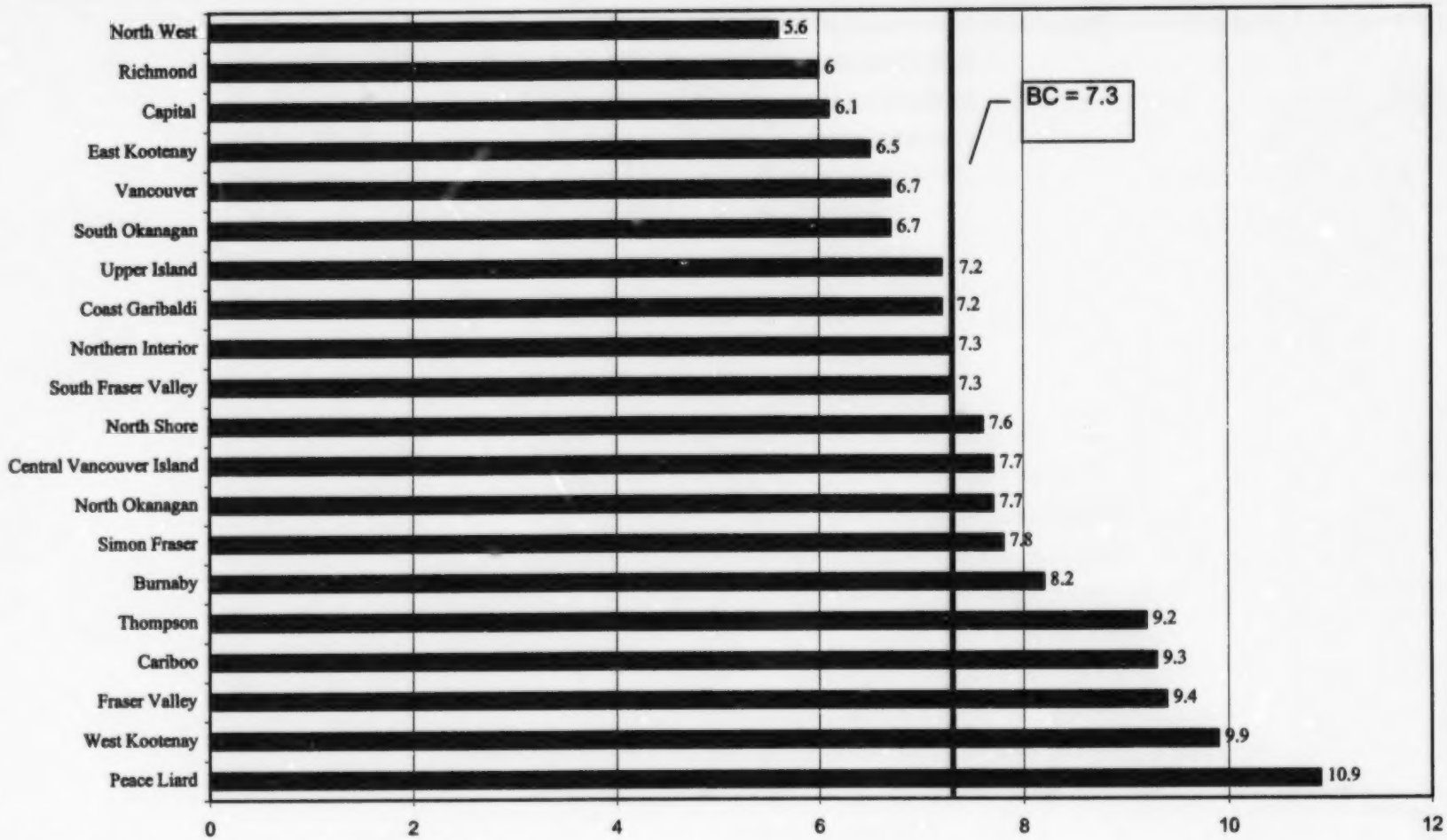
The reasons are not entirely clear for the variations among the health areas. The reasons may be related to a complex distribution of risk factors and treatment services throughout the health regions of the province. Further research is needed in this area.

In addition to the negative impact on quality of life, the health care and workplace costs associated with these diseases and conditions are immense. It is recommended that health authorities and planners focus on prevention strategies that:

- reduce the prevalence of such conditions; and,
- reduce the negative impact on quality of life that results from such illnesses.

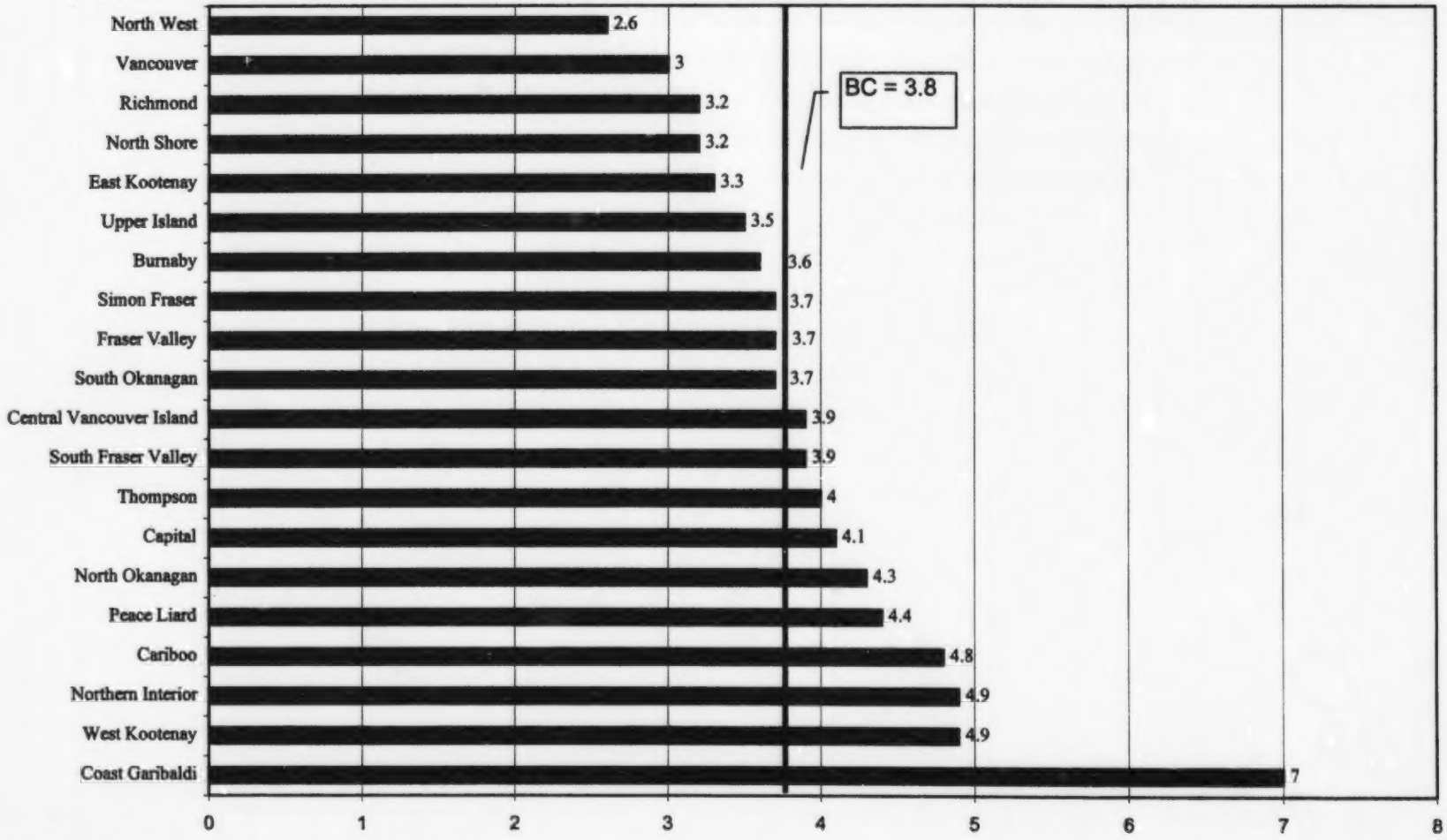
Given the variation among health regions for each of the illnesses, it is recommended that health care authorities and planners also work towards investigating the reasons for the disparities.

Graph 12: Age Standardized Female Mortality Rate By Ischaemic Heart Disease Per 10,000 Women, 1998



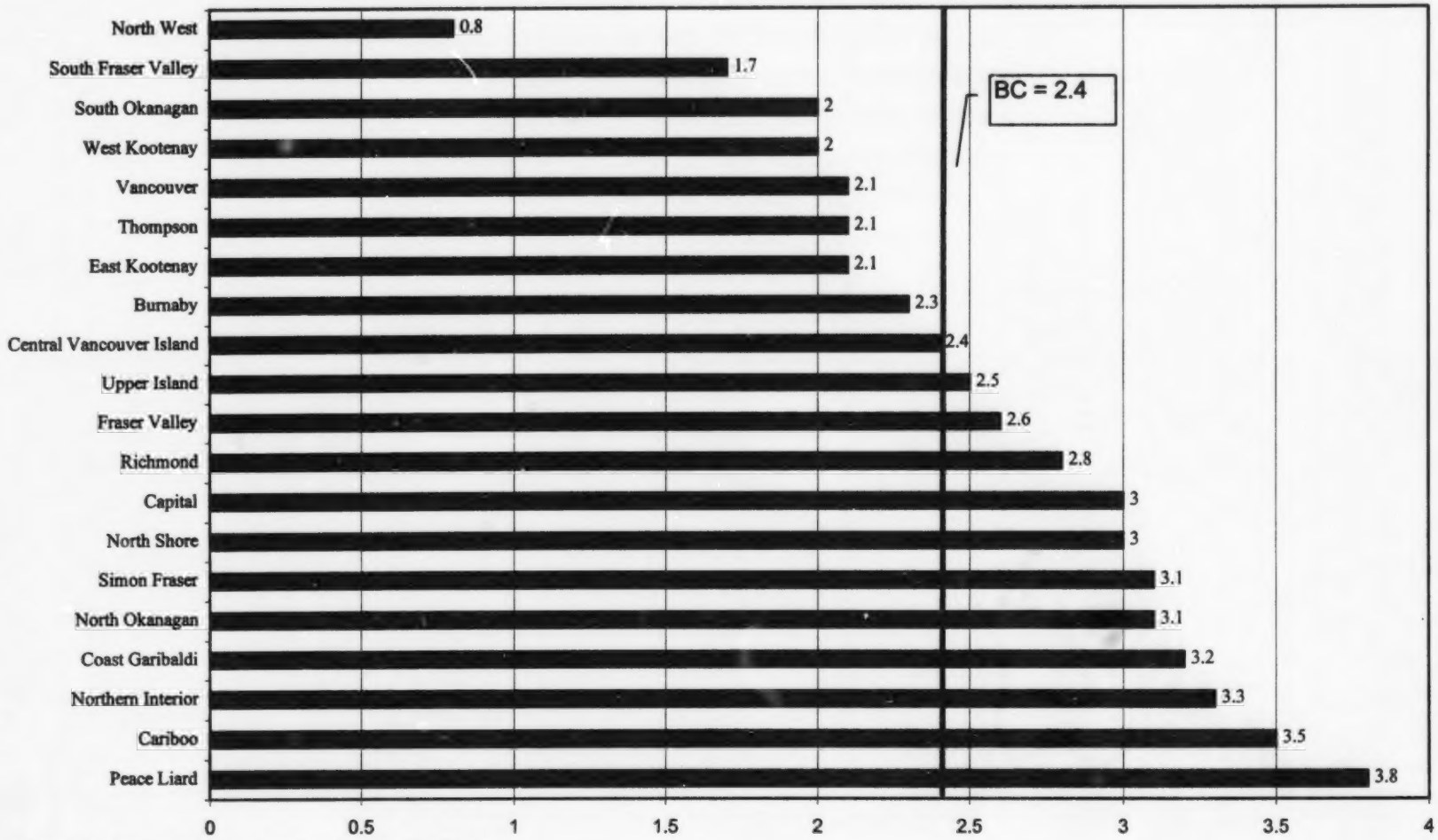
Source: BC Vital Statistics Agency, Unpublished Tables

Graph 13: Age Standardized Female Mortality Rate By Lung Cancer Per 10,000 Women, 1998



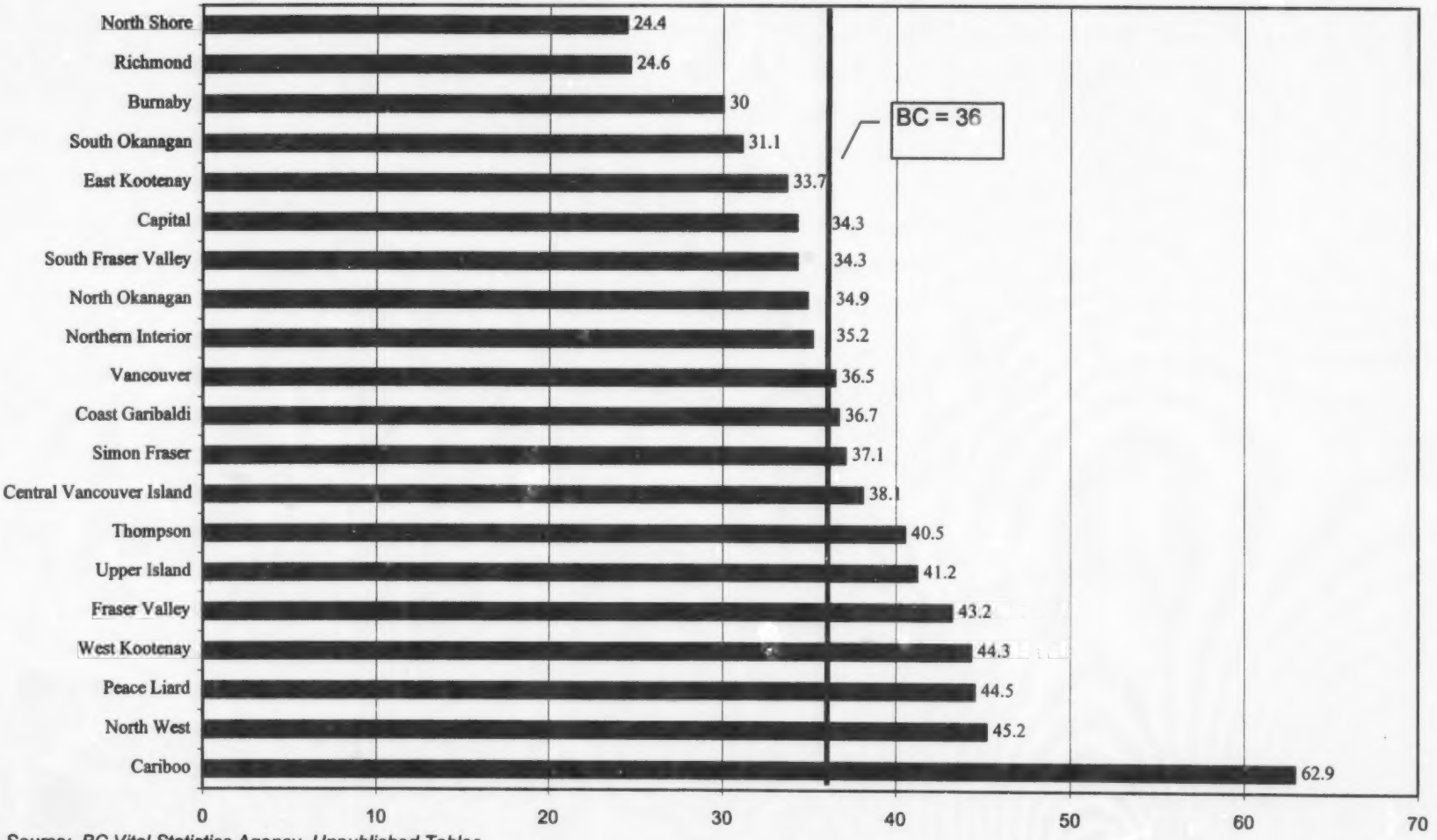
Source: BC Vital Statistics Agency, Unpublished Tables

Graph 14: Age Standardized Female Mortality Rate By Breast Cancer Per 10,000 Women, 1998



Source: BC Vital Statistics Agency, Unpublished Tables

Graph 15: Potential Years Of Life Lost Standardized Rates Per 10,000 Standard Population For Females, All Causes of Death, 1998



Source: BC Vital Statistics Agency, Unpublished Tables

CONCLUSION

The information presented in this overview reveals similar findings to those presented in the *Provincial Health Officer's Annual Report (1995) — Feature Report: Women's Health.*

Several important findings demonstrate that:

- although women have a longer life expectancy than men, there is evidence that they are not enjoying a high quality of life throughout those years;
- women are more likely than men to have lower incomes, to experience poverty, be on income assistance, and be lone parents;
- women are more likely to experience violence at the hands of someone known to them;
- most women experience a high level of reproductive health, although there is evidence that women in certain health regions are unable to access the full range of reproductive health services. In addition, many women experience unintended pregnancies and sexually-transmitted diseases. Many of these problems could be alleviated through education, preventive practices, early detection and access to comprehensive reproductive and sexual health services;
- many women may be receiving unnecessary and inappropriate health care services, as shown by regional variations in caesarean sections and hysterectomies; and,
- several populations of women experience unemployment, violence, poverty, barriers to the health care system, and lower education and quality of life than others. These include Aboriginal women, women with disabilities, senior women, adolescent girls, women from visible minority groups, and lesbians.

How women are valued in society has a direct impact on their health. Women in BC "do not enjoy the same social status as men, as is shown by the fact that they receive less pay for the same work, are victims of violence, often live in poverty, and are under-represented in decision-making bodies" (Provincial Health Officer's Annual Report 1995, p. 180). Solutions to these problems require consideration of a wide variety of issues including: "how women are valued in our society, the social and economic conditions in which they live, the personal responsibility that women are able to take for their own health, lifestyle choices they are able to make, and their ability to access both preventive and treatment services" (Provincial Health Officer's Annual Report 1995, p. 180).

There is an ongoing need to both collect and analyze data by gender in order to measure the health of women in BC. It is also important to collect data on appropriate indicators about the health of marginalized women, who are under-represented or not currently identified in health data and information.

Women's health comprises much more than diseases and physical conditions. It involves emotional, social, cultural, spiritual and physical well-being and it is influenced by the social, political and economic context of their lives. In order to meet the health needs of more than half the population of British Columbia, the health planning process must take steps to ensure that programs and services are accessible to women, appropriate for women and sensitive to the unique health care needs of women as well as the context of women's lives.